2010 Medical Benefits Highlights - Most City of Seattle Retirees Under Age 65

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet.

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
No Deductible	$200 per person $600 per family Deductible applies except for prescriptions, preventive visits, ambulance, and durable medical equipment, except as noted.	$400 per person $1,200 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$1,000 per person $3,000 per family	$100 per person $300 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$450 per person $1,350 per family
Annual Out of Pocket Maximum (OOP Max) Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max.					
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,000 per person $3,000 per family	$2,000 per person* $6,000 per family*	$2,000 per person $4,000 per family	$3,000 per person* $6,000 per family*
Maximum Lifetime Benefits Payable					
Combined $2,000,000 lifetime maximum for Standard and Deductible plans		Combined $2,000,000 lifetime maximum in- and out-of-network for Traditional and Preventive plans			
Hospital Copay					
$200 per admission	Deductible applies	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Hospital Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by GHC		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.		Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.
COVERED EXPENSES					
Acupuncture					
$15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral.	$15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral. Deductible applies.	Paid at 80% Maximum of 60 visits per calendar year in- and out-of-network combined. Provider must submit medical necessity statement at 20th visit.	Paid at 60%	Paid at 100% after $15 copay Maximum of 60 visits per calendar year in- and out-of-network combined. Provider must submit medical necessity statement at 20th visit.	Paid at 60%
Alcohol/Drug Abuse Treatment					
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 100% after deductible Outpatient: Paid at 100% after $15 co-pay. Deductible applies.	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Contraceptives					
For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.	
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%

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Emergency Medical Care					
➢ **Urgent Care Clinic**					
Paid at 100% after $15 copay	$15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay (no fee for preventive care)	Paid at 60%
➢ **Emergency Room (copays waived if admitted)**					
GHC facility: $100 copay Non-GHC facility: $150 copay	GHC facility: $100 copay Non-GHC facility: $150 copay Deductible applies	Paid at 80% after $150 copay	Paid at 80% after $150 copay. If non-emergency, paid at 60% after copay.	Paid at 90% after $150 copay	Paid at 90% after $150 copay. If non-emergency, paid at 60% after copay.
➢ **Ambulance**					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Hearing Aids (per ear, every 36 months)					
Up to $1,000	Up to $1,000	Up to $1,000 In-network coinsurance applies whether purchased in or out-of-network. Deductible does not apply.	Up to $1,000	Up to $1,000 In-network coinsurance applies whether purchased in or out-of-network. Deductible does not apply.	Up to $1,000
Home Health Care					
Paid at 100% when authorized. No visit limit.	Paid at 100% when authorized. No visit limit.	Paid at 80% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60%	Paid at 90% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60%
Hospital Inpatient					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible.	Paid at 80% after $200 copay. Physician services paid at 70% if Aexcel** specialist not used in specialty areas.	Paid at 60% after $200 copay	Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel** specialist not used in specialty areas.	Paid at 60% after $200 copay
Hospital Outpatient					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80% after deductible. Physician services paid at 70% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible	Paid at 90% after deductible. Physician services paid at 80% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Lifetime maximum of 6 months or $10,000, whichever is greater. 14-day inpatient limit; 120-hour outpatient limit.	Paid at 60%	Paid at 90%	Not covered
Maternity Care (delivery & related hospital)					
Paid at 100% after $200 copay	Deductible applies.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid 100% after one $15 copay	Paid at 60%
Mental Health Care (inpatient)					
Paid at 100% after $200 copay	Paid at 100% after deductible.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay

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Mental Health Care (outpatient)					
Paid at 100% after $15 copay per individual, family or couple session.	$15 copay per individual, family or couple session. Deductible applies.	Paid at 80% after deductible. Coinsurance does not apply to OOP Max.		Paid at 100% after $15 copay	Paid at 60% after deductible. Coinsurance applies to OOP Max.
Physician Office Visit					
Paid at 100% after $15 copay.	Paid at 100% after $15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay per visit (waived for preventive care)	Paid at 60%
Prescription Drugs (retail)					
For a 30 day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay.	For a 31-day supply: **Generic**: 30% coinsurance. **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered
Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay.	Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay.	Coinsurance applies to the prescription $1,200 out-of-pocket annual maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment). City pays $20 per month, and plan participant pays remaining; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy.			
Prescription Drugs (mail order)					
For a 90 day supply: **Generic**: $45 copay **Brand:** $90 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the OOP Max.	For a 90 day supply: **Generic**: $30 copay **Brand:** $60 copay	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	Not Covered	For a 90-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	Not Covered
Preventive Care					
Paid at 100% after $15 copay Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 100% after $15 copay Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening Hearing exams subject to deductible.	Mammograms paid at 80%. No other preventive services are covered	Mammograms paid at 60%	Paid at 100% (copay waived) Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 60% for well woman care and mammograms. No other preventive services covered
Rehabilitation Services (inpatient)					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible.	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maximum of 60 days per calendar year (combined with other therapy benefits)		Maximum of $50,000 per condition for in- and out-of-network combined		Maximum of 120 days per calendar year for in- and out-of-network combined	

Rehabilitation Services (outpatient)					
Paid at 100% after $15 copay Maximum of 60 visits per calendar year (combined with other therapy benefits)	$15 copay	Paid at 80% Includes physical/massage, speech, and occupational therapy. Maximum of 60 visits combined per calendar year. Coinsurance does not apply to OOP Max. Provider must provide medical necessity statement at 20th visit.	Paid at 60%	Paid at 100% after $15 copay Includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 60 visits combined per calendar year including in- and out-of-network. Provider must submit medical necessity statement at 20th visit.	Paid at 60%
Skilled Nursing Facility					
Paid at 100%. 60 day maximum per calendar year.	60 day maximum per calendar year. Paid at 100% after deductible.	Paid at 80% after $200 copay Maximum of 90 days per calendar year for in- and out-of-network combined	Paid at 60% after $200 copay	Paid at 90% after $200 copay Maximum of 120 days per calendar year for in- and out-of-network combined	Paid at 60% after $200 copay
Smoking Cessation					
Paid at 100% for individual or group sessions Nicotine replacement therapy included in Prescription Drug benefit	Paid at 100% for individual or group sessions	Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand drugs. See Prescription Drugs, retail.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered
Spinal Manipulations					
Paid at 100% after $15 copay Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	$15 copay. Deductible applies.	Paid at 80% Maximum of 10 visits per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $15 copay Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 60%
Sterilization Procedures					
Outpatient: Paid at 100% after $15 copay	Outpatient: $15 copay. Deductible applies.	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Tooth Injury (due to accident)					
Not covered	Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay for office visit. Other charges paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Vision Hardware and Exam					
Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100% Hardware: Two lenses per calendar year; $20-$40 per lens; frames; $30 every other year		Exam: Paid at 100% Hardware: Not covered. Discounts available through www.eyemed.com	
X-ray and Lab Tests					
Paid at 100%	Paid at 100%. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

** Applies to Aetna – Aexcel network, a specialty network of doctors in 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum).

Plan details are in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp. **This document is not a contract.**